RENDERING PROVIDER FORM

Mail to: Department of Mental Health
Chief Information Office Bureau
Systems Access Unit
695 South Vermont Avenue
Los Angeles, CA 90005

Request Type

Submit Date | | | | | | |

☐ New ☐ Update License Reporting Unit Effective Date ☐ Terminate ☐ Name Change

General Information

Last Name:

First Name:

Middle Initial: Sex: M F Ethnicity | |

DMH/NGA Staff Code | | | | | | | | |

FFS Ind Prov No. | | | | | | | | | |

SSN (Last 4 only) | | | | |

Language Code | | | | | | | | | | |

Select DMH Classcode:
☐ DMH
Prov name: _____

☐ DHS
Prov name: _____

☐ Non-Governmental Agency (DMH Contracted)
L.E. #: _____
L.E. Name: _____

☐ FFS Individual ☐ FFS Group ☐ FFS Org

Tax Payer ID (FFS only) | | | | | | | | |

Contact & Assigned Location Information

Contact name: _____ Contact Email: _____

Contact phone no: ( ) _____ Contact Fax No: ( ) _____

☐ **Add this rendering provider in the service location indicated below: (please use form MH-228A for additional locations)**

☐ **Delete this rendering provider in the service location indicated below.** ☐ **Delete this rendering provider in ALL service locations within the legal entity indicated above.**

DMH/NGA Prov No./Rept Unit | | | | | | FFS Group/Org Prov No. | | | | | | | | | |

(Please enter the provider no. associated to the above taxpayer ID)

Effective Date | | | | | | | | Termination Date | | | | | | | | Locum Tenum | | Intern | |

Name of Organization: _____ Service Area | | MHSA | |

Address: _____ City: _____ Zip: _____

Taxonomy and License Information (Required if request type is NEW)

Description: _____ Taxonomy | | | | | | | | | | |

Professional License # | | | | | | | | | | Effective Date | | | | | | | | Expiration Date | | | | | | | |

Description: _____ Taxonomy | | | | | | | | | | |

Professional License # | | | | | | | | | | Effective Date | | | | | | | | Expiration Date | | | | | | | |

DEA License # | | | | | | | | | | Expiration Date | | | | | | | |

Medicare Prov No. (DMH directly-operated only) | | | | | | PPIN Medicare No. (DMH directly-operated only) | | | | | | | | | | Expiration Date | | | | | |

NPI | | | | | | | | | | | NPI Effective Date | | | | | | | |

Authorized Manager/Designee Signature: _____ Print Name: _____ Date: _____

CIOB USE ONLY

Rendering Provider IS No: _____ Ticket # _____

Date Processed | | | | | | Processed by: _____